ARLINGTON®

Retiree Benefit Guide

Table of Contents

As a retiree with the City of Arlington, you have a number of important benefit decisions to make within 31 days of your retirement and annually thereafter. This booklet includes information regarding retiree plan offerings. Additional resources are available on the City website www.arlingtontx.gov. Select **City Programs** drop down box on left side of City website. Then select **Retirees**. Next select **City Benefits**.

REQUIRED NOTICES:

Warning:

Any intentional false statement in your enrollment or willful misrepresentation relative thereto is subject to financial restitution.

Eligibility

Retiree Eligibility

Retirees who wish to enroll in the benefit plans described in this guide must meet the following criteria:

1. Eligible for retirement with the Texas Municipal Retirement System (TMRS)
2. Retired from the City of Arlington
3. Have a minimum 10 years of eligible service with the City of Arlington

New Retirees: When eligible, you are required to enroll no later than 31 days after your retirement. If enrollment is not completed within this time period, no coverage will be available for the remainder of the plan year.

Social Security Number Requirement

Effective immediately, the Centers for Medicare and Medicaid requires the City of Arlington obtain the Social Security number (SSN) for all family members enrolled in City benefits. Enrollments will only be accepted if a Social Security number is provided for each family member.

Medicare Card Requirement

The Centers for Medicare and Medicaid have established coverage rules to determine which plan is considered primary and secondary when you or a family member becomes eligible for Medicare as required by current Federal regulations. Eligibility may be due to a disability prior to age 65 and/or attainment of age 65. Benefits under the City's plans may be reduced when you or a family member becomes eligible for Medicare as required by federal regulations.

It is the retiree's responsibility to notify Workforce Services of an individual's eligibility for Medicare. **You are required to provide a copy of the Medicare card for all family members who are eligible or who become eligible while you are employed or retired when you are enrolled in any City benefit plan.**

What happens to my coverage when I become 65: Medical and pharmacy coverage in the Value, Core or Plus and Pharmacy Plan will end the last day of the month prior to the month you become age 65.

Medicare Supplement Plans: Participants age 65 and over who wish to remain on a City of Arlington health plan must choose either a Medicare Advantage Plan which includes pharmacy coverage or an AARP Plan with or without separate pharmacy coverage.

The enrollment form and information are located on the City website at www.arlingtontx.gov on the retirees section of the website. **Contact Workforce Services 90 days prior to your attainment of age 65.**

How much will the City contribute toward my retiree medical benefit?

Refer to rate charts located on the City website at www.arlingtontx.gov.

NEW RETIREES: To receive a City contribution, you must be a minimum of age 50 **and** your age plus years of service **with the City of Arlington** must equal at least 70. (For individuals who were already eligible to retire when these rules became effective 01-01-2008, these requirements will be waived.)

This will not prevent employees from retiring and enrolling in the plan prior to age 50 and paying the full cost for the medical plan. At the time they reach age 50 **and** the age required to meet the rule of 70, these retirees are eligible to enroll in the current benefit plans being offered at the City of Arlington, or if already enrolled, begin to receive a City contribution. However, enrollment must be within 31 days of eligibility. Retirees may request enrollment materials during any annual enrollment period.

RETIRED PRIOR TO 01/01/2008: The City will contribute an amount based on the Core Plan cost, your years of service range, and the percentage of cost applicable to your service range. Your dependent coverage will also receive a percentage contribution equal to half the percentage of the contribution for you. (Example: 20-24 years of service, City pays amount equal to 80% of Core Plan cost for you and 40% for your dependents.) Refer to rate charts located at www.arlingtontx.gov.

RETIRED 01/01/2008 OR LATER: The City contribution will be an amount based on the Core Plan and your years of service. The City's contribution for retirees under age 65 will be calculated using 5% of the single coverage rate (retiree only) for the Core Plan multiplied by each complete year of service (maximum 30 years). Refer to rate charts located at www.arlingtontx.gov.

The City's contribution for retirees age 65 and over will be calculated using 5% of the single coverage rate (retiree only) for the Secure Horizons Medicare Advantage Plan multiplied by each complete year of service (maximum 30 years).

The City's contribution is applied to the retiree's medical cost.

Dependent Eligibility

NOTE: IT IS THE RETIREE'S RESPONSIBILITY TO DROP COVERAGE WHEN A DEPENDENT IS NO LONGER ELIGIBLE.

If a dependent becomes ineligible, an enrollment change is required within 31 days. The retiree is responsible for reimbursing the City of Arlington for any benefit payments made or coverage provided for an ineligible dependent. If at any time an ineligible dependent is enrolled in coverage or remains enrolled in coverage when they do not meet the eligibility criteria described in this guide or the full Summary Plan Description, the retiree will be responsible for all IRS tax implications (including penalties assessed by the IRS) and must reimburse the City for all contributions made on behalf of the ineligible dependent. If you fail to make the coverage change within the required 31 days, the dependent remains ineligible for benefits, however, required monthly contributions will not change for the remainder of the plan year. You will then be required to make the change during the next annual enrollment period to become effective January 1 of the next plan year.

You may not be enrolled as both a retiree and a dependent in any City of Arlington plan.

Effective January 1, 2010, the Centers of Medicare and Medicaid require the City to obtain each family member's social security number to allow enrollment in City benefits. Coverage may not begin for a family member other than a newborn or newly adopted child without a social security number. The retiree is required to provide the social security number for newborn/adopted child as soon as possible and within a reasonable amount of time.

Who is considered an eligible dependent for enrollment in City of Arlington benefit plans?

Eligible Dependent	Documentation Required
Legal spouse	1. Marriage license 2. Informal Marriage Form 3. Joint tax return (most recent)
***Child,** stepchild, legally adopted child, child placed for adoption, or a child for whom legal guardianship has been awarded. - Child must be under age 26 effective 1.1.2011.	1. Birth certificate 2. Tax return (most recent) 3. Adoption documentation 4. Legal guardianship documentation
Qualified Medical Child Support Order (QMCSO)	Medical Support Order

* A retiree or spouse must remain enrolled in an under-65 plan for dependent(s) to have coverage through the City's retiree benefit plans. Dependent coverage ends on the date both the retiree and spouse are no longer eligible for an under-65 plan offered through the City. Dependent children will be provided continuation of coverage information (COBRA) which they may elect for up to a 36 month period.

(see next page for Ineligible Dependents)

Ineligible Dependents

There are instances when the IRS may allow you to claim an individual for tax reporting purposes as a dependent, but that does not qualify them to enroll in City of Arlington benefit plans. Some examples of individuals not eligible for the City of Arlington benefit plans include:

• Father	• Father-in-law	• Uncle	• Grandfather	• Boyfriend
• Mother	• Mother-in-law	• Aunt	• Grandmother	• Girlfriend
• Brother	• Brother-in-law	• Nephew	• Grandchild	• Ex-spouse
• Sister	• Sister-in-law	• Niece	• Cousin	• Domestic partner

WARNING: *Any intentionally false statement in your enrollment or willful misrepresentation relative thereto is subject to financial restitution.*

Retiree Payments

As a result of a growing retiree population and escalating healthcare costs, the City finds it necessary to establish guidelines regarding non-payment of benefit contributions as well as checks that have been returned by the bank that were submitted to the City for benefit payments.

Retirees are notified of the monthly payment when they retire and each year prior to January 1. Benefit payments are due on the 1st of each month and must be paid in full on or before the due date. Payments may be made monthly, quarterly, or annually. If payments are not received in Finance by the 5th of the month, a 5% late fee will be imposed on each payment that is past due. A month's contribution and associated late fee must be paid in full no later than 60 days past the due date to avoid cancellation. If there are two payments past due, both month's premiums and associated late fees must be paid in full no later than 60 days past the first month's premium due date to avoid cancellation.

Benefit payments also become past due when a check that was sent in is returned by the bank. Returned checks will incur the City's returned check fee of $25. Payment must be made in full each month on the due date.

Retirees with past due premiums and associated late fees due to non-payment or returned checks will be subject to cancellation of their health, dental and vision benefits if payments and associated late fees remain unpaid for 60 days.

Past Due 30 days – First Notice will be sent to retiree.
Past Due 45 days – Second Notice will be sent to retiree by certified mail.
Past Due 60 days – Cancellation Notice will be sent to retiree by certified mail.

If all payments and/or late fees are not received in full within the 60 day time frame, notice will be given to Workforce Services to process a cancellation of the retiree's benefit coverage. Retirees who have had their coverage cancelled for late payment or non-payment **will NOT be eligible to reinstate their benefits**.

If you have questions, please contact the Retiree/Payroll Clerk at 817-459-6263.

Retiree Personal Information Update!

It is the responsibility of all participants to notify the City of any changes in address, e-mail address and phone number. Please mail to:

City of Arlington
Workforce Services
PO Box 90231, MS 63-0790
Arlington, TX 76004-3231

Changing Benefit Elections

LIFE EVENTS

You may be allowed to make a change in your coverage during the year for the following reasons:

- You marry or divorce;
- You gain a dependent due to birth, adoption, placement for adoption, eligibility under a Qualified Medical Child Support Order, legal guardianship, or lose a dependent due to ineligibility or death;
- You or your spouse obtains or loses a job which changes eligibility for coverage;
- You or your spouse experiences a significant change in employment status (for example, going from full-time to part-time) which changes eligibility for coverage;
- Your child is no longer eligible because of the plan's limiting age; or
- You or your spouse take or return from an unpaid leave of absence that affects coverage.

YOUR SPECIAL ENROLLMENT RIGHTS

You, your spouse, or your children may be entitled to enroll in the medical, dental and vision plans at times other than annual open enrollment. Generally, you may enroll in these plans when:

- Other coverage ends because you and/or your dependents are no longer eligible;
- You and/or your dependent exhaust COBRA coverage under another employer's plan;
- You gain a dependent, you marry, have a new child by birth or adoption, or a child is placed with you for adoption; or
- An employer sponsoring the other coverage is no longer making contributions toward the cost of coverage.

NOTE: All changes must be made within 31 days of the life event. Documentation must be forwarded to the Workforce Services department. If you are not able to provide documentation to Workforce Services for any reason within the 31 day period, you are still REQUIRED to complete a Retiree Benefit Election form and forward to Workforce Services within the 31 day period. The form is located on the City website at www.arlingtontx.gov.

Proof Requirement – Documentation of all mid-year requests to change (start or stop) a benefit plan due to a family status change/life event is required to be provided to Workforce Services **within 31 days of the life event.** Typical documentation would include the name and date of birth of the family member who has either gained or lost coverage and the effective date of the gain or loss. Document examples include, but are not limited to COBRA notices, Certificate of Healthcare Coverage forms, employer letterhead outlining the details including the date of gain or loss of specific coverage. Enrollment of a dependent with a different last name will require proof of dependent status.

RETIREES MUST BE ENROLLED IN A BENEFIT PLAN TO ALLOW ANY ELIGIBLE DEPENDENT TO ALSO ENROLL IN THE PLAN.

Declining Coverage or Cancellation of Coverage

Retirees and their eligible dependents may drop medical coverage and re-enter the plan based on the following criteria:

- At any time during the year if the change is qualified as outlined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), or
- During the annual open enrollment period with coverage becoming effective January 1 of the plan year following the annual open enrollment period.

The retiree will be eligible for the City contribution in place at the time of re-enrollment for themselves and their dependents based on their applicable years of service with the City. Retirees must remain on the plan in the same type coverage to allow a spouse or child to enroll. Surviving spouses may continue medical coverage through the City only if they were enrolled in the same type benefit plan at the time of the retiree's death **and have not remarried.**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage,

you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days of the marriage, birth, adoption, or placement for adoption.

NOTE: Once a participant has dropped coverage and is re-enrolling in the plan, pre-existing conditions may apply for those 19 years of age and older.

Dental Plans

Dental Plans

The City's dental coverage is administered by MetLife effective 1.1.2011. You may choose one of three dental plans as described below:

- A Dental Health Maintenance Organization (DHMO) plan which pays benefits only when you use network providers located exclusively in Texas; or
- Two Preferred Provider Organization (PPO) dental plan options which offer more freedom in your dental selections. You may choose any dentist, in or out of network, including specialists.

DENTAL HEALTH MAINTENANCE ORGANIZATION PLAN (DHMO)

The DHMO Plan has no deductible and has the lowest cost. However, when you are enrolled in the DHMO plan, you must first be enrolled with a network dentist before scheduling appointments. When you enroll in the DHMO plan, you must contact MetLife Dental to enroll with a network dentist and/or to change your dentist. Please be sure there is a network dentist convenient to your location before enrolling in this plan option.

All specialist referrals must be pre-approved by Metlife. You pay co-payments according to the plan's schedule. Co-payments vary depending on the services. There are no pre-existing condition exclusions and no annual maximums. You may call 1.800.942.0854 for assistance with selecting a dentist or to request a provider listing.

PREFERRED PROVIDER ORGANIZATION PLANS (PPO)

MetLife offers two preferred provider organization plans which cover both in and out of network services. However, out-of-pocket expenses are typically less when you select in-network providers. The two plans differ in the amount of maximum annual benefits and co-insurance required.

HIGH PPO PLAN - The High PPO Plan reimbursements are based on usual and customary (U&C) fees. Some dentists may charge more than the U&C rate, and you will be responsible for charges that exceed the reimbursed rate. Benefits are subject to a $50 deductible for most services, and there is an individual maximum benefit of $1,500 each year. Waiting periods for some services are required. Participants are encouraged to investigate waiting periods for applicability prior to having or scheduling procedures.

LOW PPO PLAN - The Low PPO Plan reimbursements are based on a maximum allowable charge (MAC) fee schedule. Dentists may charge more than the MAC rate. Participants are responsible for charges that exceed the reimbursed rate. Benefits are subject to a $50 deductible for most services, and there is an individual maximum benefit of $750 each year. Waiting periods for some services are required. No orthodontic services are available on this plan. Again, participants are encouraged to determine if waiting periods are applicable prior to scheduling procedures.

Additional information regarding dental plan options is available on the City website located at www.arlingtontx.gov.

Refer to Dental Plan rate chart for monthly rates located on City website at www.arlingtontx.gov.

DENTAL PLAN COMPARISON:

Plan Feature	DHMO Plan (In-Network ONLY)	Low PPO Plan (In- or Out-of-Network)	High PPO Plan (In- or Out-of-Network)
Deductible (calendar year)	None	$50 per person/Maximum $150 ($50 x 3)	$50 per person/Maximum $150 ($50 x 3)
Preventive care: one visit every six months for a routine checkup, cleaning and polishing	Plan pays 100% after a $5.00 appointment co-pay and you must first be enrolled with a network provider.	Plan pays 80% of eligible dental fees. Deductible does not apply.	Plan pays 80% of eligible dental fees. Deductible does not apply.
Basic care: fillings, extractions, root canal therapy, scaling of teeth and basic oral surgery.	You pay a fixed co-pay according to the plan's schedule and you must first be enrolled with a network provider.	Plan pays 60% of eligible dental fees after deductible is met.	Plan pays 80% of eligible dental fees after deductible met.
Major care: bridges, dentures, crowns, inlays, onlays, and complex oral surgery	You pay a fixed co-pay according to the plan's schedule and you must first be enrolled with a network provider.	Plan pays 50% of eligible dental fees after deductible is met. Waiting periods may apply.	Plan pays 50% of eligible dental fees after deductible met. Waiting periods may apply.
Maximum annual benefit	No limit	$750 per person	$1,500 per person
Orthodontic care	See fee schedule (adults & children under age 25)	No coverage	50% with a lifetime maximum of $1,000 (children under 19 only)
Waiting Period	N/A	12 months for some services *	12 months for some services*

* Refer to summary plan description for services subject to waiting periods.

Refer to schedules and summary plan descriptions located on the City's website, located at www.arlingtontx.gov.

Under 65 Medical Plan Options

The City of Arlington currently offers three medical plan options through United Healthcare's Choice network of physicians. All plans provide in-network benefits only. All out-of-network services are the full responsibility of the covered member.

Although a primary care physician is not required, you are encouraged to choose a primary care physician (PCP) from the UnitedHealthcare Choice network to coordinate your health care. Additionally, referrals are not necessary to see a specialist in the UnitedHealthcare Choice network.

All plans offer the same covered services and the network providers are identical. Consult the Summary Plan Description located on the City's website, located at www.arlingtontx.gov, for plan details.

1. Core Plan (Choice In-Network Providers/ Facilities ONLY)

- $1,000 per person, $2,000 per family deductible.
- Deductible must be paid before the plan pays medical benefits (other than preventive care).
- After the deductible has been met for the plan year, the plan pays co-insurance of 80% and participants are responsible for 20% of eligible expenses.
- The co-insurance applies to eligible medical services, whether at the physician's office, the emergency room, outpatient surgery, or hospital admissions.
- The maximum co-insurance you pay is $4,000 per person or $8,000 per family (deductibles not included).
- The plan covers preventive care services at 100% not subject to the deductible. Preventive services include services as defined by the United States Preventive Services Task Force.

2. Plus Plan (Choice In-Network Providers/ Facilities ONLY)

- $750 per person, $1,500 per family deductible.
- Deductible must be paid before the plan pays medical benefits (other than preventive care).
- After the deductible has been met for the plan year, the plan pays co-insurance of 80% and participants are responsible for 20% of eligible expenses.
- The co-insurance applies to eligible medical services, whether at the physician's office, the emergency room outpatient surgery, or hospital admissions.
- The maximum co-insurance that you pay is $3,000 per person or $6,000 per family (deductibles not included).
- The plan pays preventive care services at 100% not subject to the deductible. Preventive services include services as defined by the United States Preventive Services Task Force.

Refer to rate charts for monthly contributions, located on the City website at www.arlingtontx.gov.

3. Value Plan (Choice In-Network Providers/ Facilities ONLY)

- The Plan deductible is $1,500 for one person, $3,000 for more than one person.
- This plan qualifies as a High Deductible Health Plan (HDHP) as outlined in the Internal Revenue Code.
- The Plan deductible **does apply toward the annual out-of-pocket maximum.**
- Medical and prescription expenses are combined under this plan to meet the annual deductible. The deductible is applied to both medical and prescription expenses
- After the deductible has been met for the plan year, the plan pays co-insurance of 90% and the participant is responsible for 10% of eligible medical expenses.

- Pharmacy coverage is based on the tier the drug is assigned after the annual deducible is met. The separate out-of-pocket maximum is $2,000 per individual.
- **When enrolled for more than one person, the full family deductible of $3,000 must be met by either one covered family member or any combination of covered family members before benefits are paid.**
- The co-insurance applies to all incurred medical services, whether at the physician's office, the emergency room, out-patient surgery, or hospital admissions.
- The maximum amount of co-insurance that you pay on this plan is $5,000 for one person or $10,000 for more than one person. Remember, unlike the Core and Plus plans, this amount includes your deductible. When enrolled for more than one person, the full family out-of-pocket amount of $10,000 must be met by either one covered family member or any combination of covered family members before medical benefits are paid at the 100% level.
- The plan pays preventive care services at 100% and is not subject to the deductible. These services are based on the United States Preventive Services Task Force guidelines.
- This plan also includes the opportunity to open and contribute to a Health Savings Account (HSA) See page 17 of this guide for explanation of the HSA plan and refer to www.irs.gov for eligibility details.

Pre-Existing Condition Exclusion Clause

All Plans exclude coverage for a **pre-existing condition that exists prior to enrollment when you have gone without coverage for more than 62 days.** Effective January 1, 2011 there are no pre-existing conditions exclusions for dependents under the age of 19. Services are excluded for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period before your enrollment date if you were not covered by another insurance plan for 63 days or more. (Your initial enrollment date is your first day of coverage.) If you had a medical condition in the past, but have not received any medical advice, diagnosis, care, or treatment within the 6 months prior to your enrollment date in the plan, your condition is not a pre-existing condition for which this exclusion will be applied.

If you are enrolling in a City plan and you have a pre-existing condition, you will need to provide UHC a copy of all certificates of creditable coverage to verify your previous medical coverage. If you have experienced a break in coverage of 63 days or more, benefits will be excluded only for conditions that are determined to be pre-existing, and no benefits will be payable for that condition for the first 12 consecutive months of coverage. Coverage in a City of Arlington medical plan is subject to the above criteria any time you waive coverage for yourself and/or eligible family members.

When considering the Value, Core or Plus Plan, **it is important to remember that the participant is responsible for paying the deductible amount before any benefits will be paid toward medical care other than preventive care services.** The plan pays 100% of eligible preventive care services. These services include, but are not limited to well baby/child care, well woman care, and annual physicals.

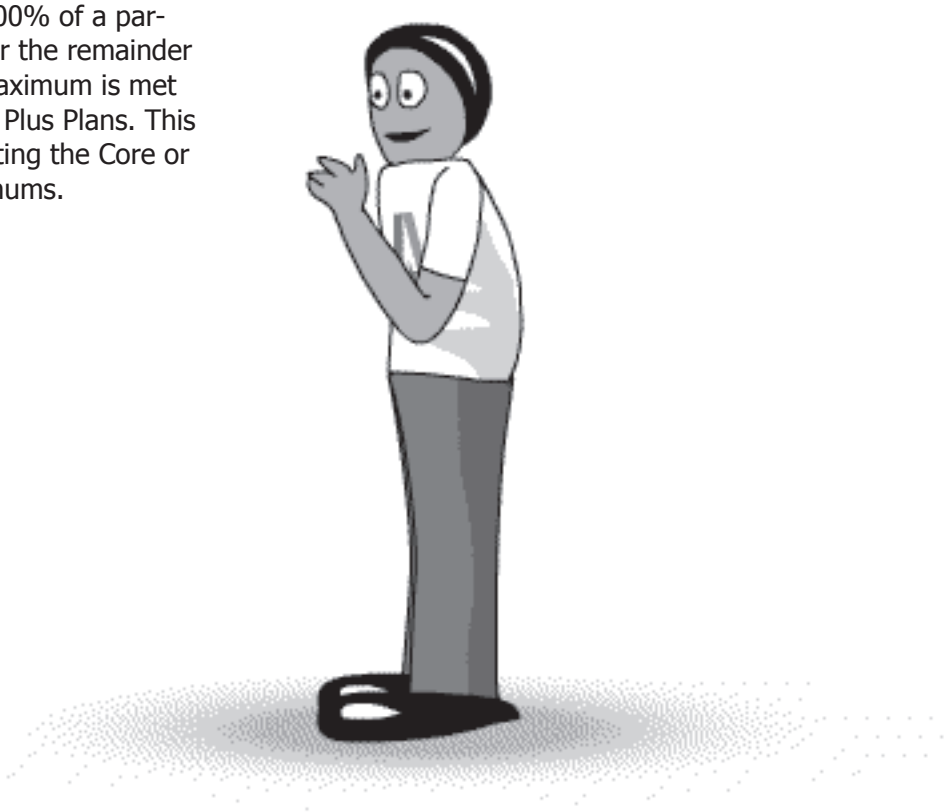
Prescription Drug Plans

The prescription benefit is a 4-tier structure and you are responsible for a percentage of the total drug cost. Typically, Tier 1 will include generic or very common drugs, Tier 2 will include preferred name brand drugs, Tier 3 will include non-preferred name brand drugs, and Tier 4 will include specialty drugs.

Tier	Example Cost	% EE Pays	% EE Cost	Health Plan Pays	Health Plan Cost
1	$ 30	15%	$ 4.50	85%	$25.50
2	$ 95	25%	$28.75	75%	$71.25
3	$200	40%	$80.00	60%	$120
4	$760	50%	$380	50%	$380

The prescription plan for all plans has a separate $2,000 out-of-pocket expense maximum per participant. The Plan pays 100% of a participant's eligible prescriptions for the remainder of the calendar year once the maximum is met when you enroll in the Core and Plus Plans. This $2,000 does not go toward meeting the Core or Plus annual out-of-pocket maximums.

For the Value Plan only, the $2,000 out-of-pocket maimum applies only after the annual deductible has been met. The $2,000 is counted toward the annual out-of-pocket maximum for the Value Plan only. Once the $2,000 out-of-pocket pharmacy maximum has been met theplan will pay 100% of the eligible pharmacy expenses for that individual.



*IN-NETWORK COVERAGE ONLY

PLANS:	Value	Core	Plus
Annual Deductible	$1,500/$3,000 Single coverage/Spouse or Family	$1,000/$2,000	$750/$1,500
Co-insurance	10% of eligible charges	20% of eligible charges	20% of eligible charges
Co-insurance Out-Of-Pocket Maximum (OOPM)	$5,000/$10,000 Single coverage/ Spouse or Family Deductible applies to out-of-pocket	$4,000/$8,000 Deductible does not apply to out-of-pocket	$3,000/$6,000 Deductible does not apply to out-of-pocket
Physician Office Visit	10% after deductible	20% after deductible	20% after deductible
Specialist Office Visit	10% after deductible	20% after deductible	20% after deductible
After Hours Office Visit	10% after deductible	20% after deductible	20% after deductible
Physical Exams	10% after deductible	20% after deductible	20% after deductible
Gyn Exams	10% after deductible	20% after deductible	20% after deductible
Preventative Care	Plan pays 100%. Services typically include, but are not limited to, well baby/child care, well woman/man care, and annual physicals.		
In-Patient Hospital	10% after deductible	20% after deductible	20% after deductible
Emergency Room	10% after deductible	20% after deductible	20% after deductible
Urgent Care Facility	10% after deductible	20% after deductible	20% after deductible
Ambulance	10% after deductible	20% after deductible	20% after deductible
Outpatient Surgery	10% after deductible	20% after deductible	20% after deductible
Mental Health: Inpatient	10% after deductible	20% after deductible	20% after deductible
Outpatient	10% after deductible	20% after deductible	20% after deductible
Radiology/Anesthesiology/ Pathology/Lab Services	10% after deductible	20% after deductible	20% after deductible
Pharmacy (local and mail order)	$2,000 separate out-of-pocket maximum (OOPM) per participant. Co-insurance based on four tiers: Tier 1 = 15%, Tier 2 = 25%, Tier 3 = 40%, *Tier 4 = 50% *specialty pharmacy		
	Each participant has to pay $2,000 in eligible pharmacy expenses after meeting the annual deductible. $2,000 pharmacy OOPM is included in the Value medical plan OOPM. Once the $2,000 in pharmacy has been paid, the plan will pay 100% of eligible expenses.	$2,000 separate out-of-pocket maximum (OOPM) per participant. Each participant has to meet a $2,000 OOPM then the City pays 100%. $2,000 does not count toward meeting the separate medical plan OOPM	$2,000 separate out-of-pocket maximum (OOPM) per participant. Each participant has to meet a $2,000 OOPM then the City pays 100%. $2,000 does not count toward meeting the separate medical plan OOPM

This comparison of benefits is a summary to assist in your evaluation of available options. The Summary Plan Description provides more details of the services and benefits for each plan and is located on the City's website at www.arlingtontx.gov.

***IMPORTANT:** All out-of-network charges are the responsibility of the participant.

Vision Plan

You may elect vision coverage through EyeMed. The plan pays benefits for annual exams and corrective lenses. You pay a co-pay for exams, and the plan pays benefits for frames and lenses up to certain limits. Under this plan, you may use in-network or out-of-network vision care providers, but you receive greater benefits when you use in-network providers.

The plan will pay for contacts or eyeglass lenses once every 12 consecutive months and frames once every 24 consecutive months.

Refer to Vision rate chart for monthly contribution, located on the City website at www.arlingontx.gov.

All plans are based on a 48-month contract term and 48-month rate guarantee

* Standard Progressive Lens covered - fund Premium Proressive as a Standard

Additional Discounts:

- Member receives a 20% discount on items not covered by the plan at network providers, which cannot be combined with any other discounts or promotional offers. Discount does not apply to EyeMed Providers' professional services, or contact lenses.
- Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.
- After intial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service.
- Benefit allowances provide no remaining balance for future use within the samd benefit frequency.
- Certain brand name vision materials in which the manufacturer imposes a no-discount practice.
- Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group.
- Rates are valid for groups domiciled in the State of TX. Fees quoted will be valid until the 1/1/2011 plan implementation date. Date quoted: 7/12/2010. Rates asume 100% employee contribution for employees and dependents.
- Insured plans are underwritten by Combined Insurance Company of America, 5050 Broadway, Chicago IL 60640 except in New York.

Vision Care Services	In-network	Out-of-network
Exam with Dilation if necessary	$10 co-payment	$40
Contact Lens Fit, Follow-up *(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed)*		
***Standard Contact* Lens** Fit, follow-up	$0 co-pay. Paid in full fit, two follow-up visits.	$40
Premium Contact Lens Fit, follow-up	$0 co-pay, $10% off retail price, then apply $40 allowance.	$40
Frames Any available frame at provider location	$0 co-pay, $130 allowance, 20% off balance over $130	$80
Standard Plastic Lenses:		
Single vision	$10 co-pay	$40
Bifocal	$10 co-pay	$60
Trifocal	$10 co-pay	$80
Lenticular	$10 co-pay	$80
Standard Progressive Lens**	$10 co-pay	$80
Premium Progressive Lens**	$10. 80% of charge less $120 allowance.	$60
Lens Options:	$15	N/A
UV Treatment	$15	N/A
Tint (solid and gradient)	$0	$8
Standard Plastic Scratch Coating	$40	N/A
Standard Polycarbonate - Adults	$0	$20
- Kids under 19	$45	N/A
Standard Anti-Reflective Coating	20% off retail price	N/A
Polarized	20% off retail price	N/A
Other Add-Ons		
Other Add-Ons:		
Contact Lenses *(contact lens allowance includes materials only)*		
Conventional	$0 co-pay; $105 allowance, 15% off balance over $105.	$105
Disposable	$0 co-pay; $105 allowance, plus balance over $105.	$105
Medically Necessary	$0 co-pay, paid in full.	$210
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promo. price.	N/A
Additional Pairs Benefit	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency		Same
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	
Monthly Rate		Same
Subscriber	$4.72	
Subscriber + 1	$9.90	
Subscriber + Family	$15.09	

65+ Medical Plan Options

All participants age 65 and over who wish to have Medicare related medical coverage through the City of Arlington must enroll in either the Secure Horizons Medicare Advantage Plan (includes both medical and Medicare Part D pharmacy coverage) or one of two AARP Medicare Supplement plan options (Plan K or F). **NOTE: Individuals enrolled in the AARP Plan J option as of 12/31/09 may remain in the Plan J. However, this option will not be offered for <u>new</u> enrollment effective January 1, 2010.**

Over 65 retirees and spouse must be enrolled in the same medical/pharmacy plan option. Split coverage is only allowed when one family member is over 65 and the other is under 65.

The Centers for Medicare and Medicaid (CMS) allows enrollment in only **<u>one</u>** Medicare Part D Plan. Your enrollment in a City sponsored plan must be approved by CMS. Every Medicare eligible participant is required to provide the City with a copy of the front of their Medicare card to ensure accurate Medicare numbers are provided to CMS.

You may enroll in a UHC Medicare Part D Pharmacy Plan through the City of Arlington or you may decline it and choose a Part D plan that is better suited to your pharmacy needs. If you attempt to enroll in more than one pharmacy plan, CMS will deny your coverage and will provide you notification that your request to be enrolled in the City's pharmacy plan has been denied.

If you decline the UHC Medicare Part D Pharmacy Plan, you must complete a decline form and submit it with your retiree change form.

All medical and pharmacy coverage in any of the pre-65 plans will end on the last day of the month prior to the month you become 65.

AARP will mail a personalized enrollment kit to the home address of participants approaching 65. Currently Secure Horizons through the City is only available to residents of Tarrant, Dallas, Denton, Johnson, Collin, Ellis, Rockwall, and Kaufman counties, and enrollment packets are available in the Workforce Services Department. Enrollment requires that you complete the appropriate form -- AARP or Secure Horizons -- and mail it directly to them in the envelope provided. You also must complete a Retiree Enrollment/Change Form and provide a copy of your AARP or Secure Horizons enrollment form to Workforce Services at the address provided on the Retiree Enrollment/Change Form.

AARP membership is required for the first year only if enrolling in an AARP Medicare supplement plan. United Healthcare will pay the membership fee for one year for <u>new AARP memberships only</u>.

Questions regarding coverage through Secure Horizons or AARP should be directed to Secure Horizons or AARP.

Health Savings Accounts

If you enroll in the Value Medical Plan, you have the opportunity (if eligible) to open a Health Savings Account (HSA) with Optum Health Bank, a United HealthGroup Bank. The Value Plan is considered a high deductible health plan under IRS code.

What are the benefits of an HSA?

- You can claim a tax deduction for contributions you, or someone other than the City, make to your HSA even if you do not itemize your deductions on Form 1040.
- The contributions remain in your account from year to year until you use them.
- The interest or other earnings on the assets in the account are tax free.
- Distributions may be tax free if you are paying qualified medical expenses (IRS Publication 969).
- Excise tax 20% in 2011 when HSA funds used for ineligible expenses.

Do I Qualify for an HSA Account?

It is very important that you verify your eligibility to open an HSA account. Following are the guidelines as outlined in the Internal Revenue Code:

- Participant must be enrolled in the City's Value Plan, which is a high deductible health plan.
- Participant cannot be covered by other health coverage, i.e. spouse's health coverage (does not apply to specific injury insurance and accident, disability, dental care, vision care and long term care).
- Participant cannot be claimed as a dependent on someone else's tax return
- Participant cannot be enrolled in Medicare
- Family cannot contribute to more than one tax-advantaged health savings vehicle (HSA or FSA)

If the participant meets the requirements, he/she may choose to open an HSA. Optum Health Bank is the exclusive HSA administrator and the City of Arlington will pay $3.00 of the monthly administrative fees associated with the account while the participant is enrolled in the high deductible Value Plan.

The bank account should be opened and contributions may begin the first full month after coverage begins on the high deductible health plan (Value Plan).

How much may I contribute to the HSA?

Contribution levels change each year for individuals/families. There is also a catch-up provision for those over age 55.

The account belongs to the participant and all annual reporting is the sole responsibility of the participant. Account holders will be required to file Form 8889 annually. Optum provides monthly on-line statements at www.myuhc.com, an annual form 1099SA by January 31 each year, and an annual form 5498SA by May 31 each year.

Refer to the City's website www.arlingtontx.gov, the IRS website www.irs.gov, Publication 969, and/or your tax advisor for additional HSA information.

US Patriot Act Screening Process

In 2001, in response to the 911 terrorism attacks, the Patriot Act was created to help the government fight the funding of terrorism and money laundering activities. Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens a bank account. The act requires banks to obtain and verify a customer's name, address, date of birth, and identification number (Social Security number) before allowing an account to accept contributions. Optum maintains a secured database, and all applicants requesting an HSA must provide this information. Then Optum will notify the participant when the account has been approved and contributions may then begin.

HSA Qualified Expenses

Effective January 1, 2011, over-the-counter medications are not covered without a prescription. Examples of qualified expense include amounts paid for doctors' fees, prescription medicines, and necessary hospital services not paid for by insurance. Qualified medical expenses are determined by the IRS. Refer to publication 969.

CARE24 Services

The City of Arlington provides Core, Plus and Value medical plan participants and their family members access to the United Healthcare Care24 services. Care24 offers access to a wide range of health and well-being information – seven days a week, 24 hours a day. Using one toll-free phone number, you may speak with registered nurses and master's level counselors who can help with almost any problem ranging from medical and family matters to personal legal, financial, and emotional needs.

When you call the same number, you can listen to audio messages on more than 1,100 health and well-being topics. If face-to-face resources are more appropriate for your situation, a Care24 representative may refer you to local, in-person support. Counselors also may refer you to a wide range of national and community resources.

Care24 nurses and counselors are available 24 hours a day, 7 days a week. Call 1-888-887-4114.

Annual Deductible: The deductible is the amount you must pay for covered health services based on contracted rates (also referred to as eligible charges/expenses) in a calendar year before the plan will begin paying benefits in that calendar year.

For example: The Value, Core and Plus Plans each have an annual deductible. When you access covered benefits (visit a physician, go to the ER, have surgery, etc.), you will pay the deductible amount first before the plan will begin reimbursing any portion of provided services. NOTE: Preventive care services are not subject to the deductible.

Annual Deductible for Family: The amount you must meet for covered family members before the plan will begin paying benefits in a calendar year.

Co-insurance: The portion of covered health care costs the covered person is financially responsible for, usually according to a fixed percentage.

Co-payment: The charge you are required to pay for certain covered heath services. Some plans have co-payments which do not apply to the out-of-pocket maximum.

Covered Health Service(s): Those health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms. Refer to the Summary Plan Description (SPD) for a list of covered services. NOTE: The SPDs are located on the city website.

A covered health service is a health care service or supply described in the summary plan description (Section 1, What's Covered—Benefits), as a covered health service, and is not excluded (Section 2, What's Not Covered—Exclusions).

Dependent: A retiree's legal spouse may be referred to as a dependent for benefit purposes. A dependent also includes children under the age of 26. The child must be either 1) your natural child, 2) a stepchild, 3) a legally adopted child, 4) a child placed for adoption, or 5) a child for whom legal guardianship has been awarded to the retiree or the retiree's spouse.

Explanation of Benefits (EOB): A summary of the adjudication or processing of a claim. Once UnitedHealthcare receives a claim for a service, it is processed and an EOB is created. You may view your EOBs on-line at www.myuhc.com. You must register to create a user name and password on myuhc.com to access your account. A health statement outlines year-to-date deductible and out-of-pocket amounts met during the calendar year.

Life Event: Includes birth of a child, marriage, adoption, death, divorce and other changes that result in a gain or a loss of coverage as defined by IRS regulations.

Medicare Advantage Plan: An enhanced Medicare plan which covers more services and has lower out-of-pocket cost than the original Medicare plan. Some plans cover prescription drugs. In some plans, like Secure Horizons, you may only be able to see certain doctors or go to certain hospitals.

Out-of-Pocket Maximum: The maximum amount of co-insurance you pay every calendar year. Once you reach the out-of-pocket maximum, as an individual or family, covered benefits are paid at 100% of eligible charges during the rest of that calendar year.

Pre-Existing Condition Exclusion (no pre-existing conditions exclusions for dependents under the age of 19): An injury or sickness that is identified as having been diagnosed or treated, or for which prescription medications or drugs were prescribed or taken, within the six month period ending on the person's enrollment date. (The enrollment date is the date the person became covered under the Plan.) A pre-existing condition does not include pregnancy. Genetic information is not an indicator, or a pre-existing condition, if there is not a diagnosis of a condition related to the genetic information.

A certificate of creditable coverage should

be provided to UnitedHealthcare when a pre-existing condition claim has been received, if other health coverage was in place for the 63 days prior to the enrollment date in the City's Plan. The accepted method of documentation will be a certificate of creditable coverage from any group health plan (including COBRA continuation coverage), HMO, individual health insurance policy, Medicaid, or Medicare. The documentation accepted will include employer, third-party administrator of health plan, insurance carrier, or Centers for Medicare & Medicaid Services (CMS). Creditable coverage will be determined by the standard method.

A pre-existing condition exclusion may apply to a retiree who is returning to the City's medical plan after any period of no coverage for more than 62 days.

Primary Plan: The plan determined to be responsible for paying benefits first based on insurance contracts including federal regulations such as Medicare and/or Medicaid. The Summary Plan Description (SPD) outlines coordination of benefit rules.

Secondary Plan: The plan determined to be responsible for paying benefits after the primary plan. Benefits may be reduced based on ineligible expenses to include Medicare ineligible expenses, and/or requirements to satisfy plan provisions such as deductibles, co-pays, or co-insurance amounts. Does not always pay or provide for 100% of out-of-pocket expenses.

Summary Plan Description (SPD): Outline of eligibility, coverage, exclusions, coordination of benefit rules, schedule of benefits, claim and appeal process, and general information about the health plan. The SPD is located on the City website located at www.arlingtontx.gov.

Supplemental Medicare Plan: A plan that supplements Medicare benefits based on eligible expenses.

Effective January 1, 2011, under the Patient Protection and Affordable Care Act (the Affordable Care Act);, City of Arlington is required to provide the following notice and disclosure regarding primary care providers (PCP) and pediatricians as PCP for a child. Also included in the required notices below is information regarding OB/GYN providers, prior authorization and referral information.

Patient Protection Disclosure Notice

The City of Arlington health plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Workforce Services 817.459.6869. Plan providers may be found by contacting United Healthcare or complete a provider search on www.myuhc.com.

For children, you may designate a pediatrician as the primary care provider for a child.

You do not need prior authorization from United Healthcare or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the UHC network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participant health care professions who specializes in obstetrics or gynecology, contact United Healthcare or complete a provider search on www.myuhc.com.

Effective January 1, 2011, under the Patient Protection and Affordable Care Act (the Affordable Care Act), the City of Arlington may not offer a medical plan that includes an individual lifetime maximum benefit. The City of Arlington health (Core/ Plus/ Value) plans do not include individual lifetime maximum benefits. However, we are required to provide you with the following Notice:

Lifetime Limit No Longer Applies and Enrollment Opportunity Notification

The lifetime limit on the dollar value of benefits under the City of Arlington medical plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact Workforce Services to request re-enrollment.

Effective January 1, 2011, under the Patient Protection and Affordable Care Act (the Affordable Care Act), the City of Arlington will extend dependent coverage for employee/retiree dependents up until they are 26. The City's previous policy included dependents up until they are 25. Following is the required Notice regarding this change:

Notice of Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before the attainment of age 26 are eligible to enroll in a City of Arlington medical, dental and/or vision plan. Individuals may request enrollment for such children for 30 days from the date of this notice. Enrollment will be effective retroactively January 1, 2011. For more information contact Workforce Services 817.459.6869.

Grandfathered Health Plan Status

The City of Arlington believes our health plan coverage is a "grandfathered plan" under the Patient Protection and Affordable are Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator - Workforce Services 817.459.6869. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Find additional information about the Affordable Care Act at www.dol.gov/ebsa/healthreform/

GENERAL NOTICE
Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become covered under The City of Arlington Texas group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It also can become available to other members of your family who are covered under the Plan when they otherwise would lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct.
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a bankruptcy proceeding under title 11 of the United States Code can be a qualifying event. If a bankruptcy proceeding is filed with respect to The City of Arlington Texas, and that bankruptcy results in loss of coverage for any retired employee under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children also will become qualified beneficiaries if bankruptcy results in loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction in hours of employment, death of the employee, commencement of a bankruptcy proceeding with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

COBRA Notice

You Must Give Notice of Some Qualifying Events

For other qualifying events - divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child - you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: City of Arlington Texas, Attention: Workforce Services, 101 S. Mesquite – Suite 790, PO Box .90231, MS 63-0790, Arlington, TX 76004-3231. If the qualifying event is divorce or legal separation, please provide a copy of the executed decree as documentation of the date of the divorce or legal separation.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered employees can elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months (36 months minus 8 months) after the date of the qualifying event. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family might be entitled to receive an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify the Plan Administrator of the second qualifying event within 60 days of the second qualifying event. Notice must be sent to: City of Arlington Texas, Attention: Workforce Services, 101 S. Mesquite – Suite 790, PO Box .90231, MS 63-0790, Arlington, TX 76004-3231. Please include a copy of your Social Security Determination letter.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension can become available to the spouse and dependent children receiving coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or it the dependent child stops being eligible under the Plan as a dependent child, but only if this second event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event occurred. In all of these cases, you must notify the Plan Administrator of the second qualifying event within 60 days of the second qualifying event. Notice must be sent to: City of Arlington Texas, Attention: Workforce Services, 101 S. Mesquite – Suite 790, PO Box .90231, MS 63-0790, Arlington, TX 76004-3231. Please include a copy of the death certificate, Medicare card(s) or divorce/legal separation decree as applicable.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contacts identified in the next section of this notice. For more information

about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

To protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep, for your records, a copy of any notices you send to the Plan Administrator.

The Plan Administrator is City of Arlington Texas 817.459.6869. The Plan Administrator is responsible for administering COBRA continuation coverage. The City of Arlington, Texas has contracted with United Healthcare to administer COBRA continuation coverage. All COBRA elections are sent directly to United Healthcare. Questions regarding COBRA elections and payments may be directed to United Healthcare's Customer Service 1.866.747.0048.

Update of Notice October 28, 2010

Important Notice from the City of Arlington About Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Arlington and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Arlington has determined that the prescription drug coverage offered by the United Healthcare Medco Pharmacy Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because this coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15 through December 31. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you are an active employee or a dependent of an active employee eligible to join a Medicare drug plan and you enroll in a Medicare drug plan, your Medco Pharmacy Plan coverage will end. Active employees and/or their dependents eligible for Medicare are not required to enroll in a Medicare Part D pharmacy plan and may remain in the Medco Pharmacy Plan only if not enrolled in a Medicare part D plan. For those active employees who elect Part D coverage, the city's Medco Pharmacy Plan will end for the employee and all covered dependents. The City's Medco Pharmacy plan does provide creditable pharmacy coverage.

Retirees and/or their dependents eligible for Medicare AND age 65 are not required to enroll in the UnitedHealthcare Medicare Part D pharmacy plan. However, pharmacy coverage ends in the Medco Pharmacy Plan upon attainment of age 65. The City offers the UnitedHealthcare Medicare Part D plan as a post 65 pharmacy option. Pre-65 retirees and/or dependents not eligible for Medicare may enroll in the Medco Pharmacy Plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the City of Arlington and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information or call United Healthcare at 1.866.844.4867 regarding your United Healthcare Medco Pharmacy Plan. NOTE: This notice is published each year prior to the open enrollment period when you can join a Medicare drug plan and if this coverage through the City's Medco Pharmacy Plan changes. You may view this notice on the City's website located at www.arlingtontx.gov. (Refer to Retirees / City Benefits) You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- ❑ Visit www.medicare.gov
- ❑ Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- ❑ Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	09/25/2009
Name of Entity/Sender:	City of Arlington
Contact--Position/Office:	Workforce Services
Address:	PO Box 90231 MS 63-0790 Arlington, TX 76004-3231
Phone Number:	817.459.6869

CMS Form 10182-CC

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and completed and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to : CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

Notice reviewed October 28, 2010

Retiree Contacts

Workforce Services Department
(enrollment and coverage questions)
City Tower, Seventh Floor
101 S. Mesquite St.., Suite 790 • 817-459-6869

Financial Services Department
(billing and payment questions)
City Tower, Eighth Floor
817-459-6263

www.arlingtontx.gov

Vendor/Plan	Member Service Phone Number	Hours of Operation	Web site
UnitedHealthcare (Medical)			**www.myuhc.com**
Customer Service			
Core & Plus Plans	1-866-633-4864	6 a.m. - 6 p.m. (Mon-Fri)	
Value Plan (Definity)	1-866-314-0335		
AARP HealthCare Options			**www.aarphealthcareoptions.com**
Pre-Enrollment Questions	1-800-392-7537	6 a.m. - 10 p.m. (Mon-Fri)	
Customer Service	1-800-523-5800	and 8 a.m. - 4 p.m. (Sat)	
Secure Horizons Medicare Advantage Plan			**www.uhcretiree.com**
Pre-Enrollment Questions	1-800-610-2660	8 a.m. - 8 p.m.	
Customer Service	1-888-867-5548	7 days a week	
UnitedMedicare Part D RX			**www.UnitedMedicareRX.com**
Questions Prior to Enrollment	1-888-556-6648	24 hours a day,	
Customer Service	1-888-867-5562	7 days a week	
Met Life (Dental)			**www.metlife.com/mybenefits**
Dental DHMO	1-800-942-0854	7 a.m.-10 p.m.	
Options PPO	1-800-942-0854	(Mon-Fri)	
EyeMed (Vision)			**www.eyemedvisioncare.com**
Customer Service	1-800-299-1358	7 a.m. - 10 p.m. (Mon-Sat) and 10 a.m. - 7 p.m. (Sun)	
UnitedHealthcare (Health Savings Account)			**www.myuhc.com**
OptumHealth Bank	1-800-791-9361	8 a.m. - 6 p.m. (Mon-Fri)	
UnitedHealthcare EAP (Employee Assistance Plan)		24 hours	**www.myuhc.com OR**
Care24 Customer Service	1-888-887-4114		**www.liveandworkwell.com**
Texas Municipal Retirement System (TMRS)		8 a.m. - 5 p.m.	**www.tmrs.com**
Customer Service	1-800-924-8677	(Mon-Fri)	